

# Patient Information

Account # \_\_\_\_\_

Date \_\_\_\_\_ Physician:  Donahoe  Gira  Lee  Yoselevsky  Amato  Krishnasamy  Sullivan

Patient Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Ph ( ) \_\_\_\_\_ Cell Ph ( ) \_\_\_\_\_ Work Ph ( ) \_\_\_\_\_

Drivers License # \_\_\_\_\_ Marital Status:  Married  Single  Widow  DivorcedEmployer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_ ex:  Male  Female

Preferred E-Mail Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Person Responsible \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different than above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Drivers License # \_\_\_\_\_

**Insurance Information:** *You must provide us with a current copy of your insurance card(s). We submit to 2 insurance plans.***Primary Insurance:** \_\_\_\_\_ ID# \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ ID# \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Vision Insurance** \_\_\_\_\_

## **Release of Information/Assignment of Benefits/Consent to Treat**

I authorize the use of this form on all insurance submissions and authorize release of information needed to process a claim to my insurance companies and permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in obtaining payment from my insurance companies but understand the provider is not responsible for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand it is my responsibility to know my insurance benefits and that I will receive a monthly statement for any balance due by me. All returned checks will be assessed a \$25 fee and will be prosecuted if not paid in full within 10 business days with a credit card or money order. I consent to the medical and surgical care as deemed advisable by my physician.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***To be signed for the following years' visits only.*** *I have reviewed the above information and it has remained exactly the same:*

Signature \_\_\_\_\_ Date \_\_\_\_\_

We accept assignment on Part B Medicare patients. You will be expected to pay your deductible and 20% coinsurance. We will only file to one secondary policy.

### Medicare Authorization

I understand that my signature requests payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HICFA 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of medical information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and the uncovered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_

Medicare Policy # : \_\_\_\_\_

### Financial Contract Agreement

Ophthalmology Consultants, Ltd is committed to your successful treatment. Please understand that payment of your account is considered a part of your treatment. If you do not have your current insurance card at the time of service you will be treated as a "self pay" patient.

- All co-pays are due prior to seeing the physician (we accept Cash, Checks, MasterCard, Visa, & Discover)
- All "self pay" patients are asked to pay this visit fee in full at the time of service unless other prior arrangements are made.
- All patients covered under an HMO plan must have a valid referral at the time of their visit
- **All delinquent accounts, 30 days past due, may be placed in collections, you may be responsible for all additional charges incurred to collect this account, including court costs and legal fees, along with a \$25 administration fee.**
- **We do not get involved with any litigation accounts, disputed workmens' compensation cases, divorce decrees, or auto accidents; you will be 100% responsible for full payment at time of service or within 90 days of service with prior arrangements with the billing department**
- The adult accompanying a minor and/or guardians of the minor are the responsible party for payment of account.

We accept assignment of benefits for insurance plans that we are contracted with. The balance is your responsibility. Your insurance is a contract between you and the insurance company. We are not a party to that contract or know exactly what benefits are included or excluded in your plan. Please be aware that some, and perhaps all of the services provided may be noncovered services and not considered reasonable and medically necessary under the Medicare program and/or other medical insurance coverage. We are not liable for any misquoted benefit information. You are fully responsible for verifying the benefits of your policy.

If you have no insurance coverage and need financial help, our Business Office personnel will be happy to help you work out an agreeable payment plan. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary in our area. Please let us know if you have any questions or concerns. I understand and agree to this Financial Contract Agreement as stated above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Release of Information/Assignment of Benefits/Consent to Treat

I authorize the use of this form on all of my insurance submissions and authorize release of information needed to process a claim to all my insurance companies. I permit a copy of this insurance authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies. I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on dispute claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due by me. The undersigned consents to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my physician or other provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Receipt of Notice of Privacy Practices/Written Acknowledgement Form

I have received a copy of Ophthalmology Consultants, Ltd. Notice of Privacy Practices dated 4/14/2003

Signature \_\_\_\_\_

Date \_\_\_\_\_

*The above authorizations are valid for the duration of the patient's care unless retracted in writing by the patient.*

Ophthalmology Consultants, Ltd.  
Medical History Form & Review of Systems

Acct # \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Social History:

Use of Alcohol: Never  Rarely  Moderate  Daily

Use of Tobacco: Never  Previously/Quit (date) \_\_\_\_\_ Current Packs/day \_\_\_\_\_

Use of Drugs: Never  Type/Frequency \_\_\_\_\_

Occupation \_\_\_\_\_

Past Medical History:

Thyroid Disease  High Blood Pressure  Heart Disease  Stroke

HIV  Hepatitis  Diabetes Mellitus  Cancer

Do you have a defibrillator ?

Other: \_\_\_\_\_

Description of Previous Surgery/Date \_\_\_\_\_

Medications: (include non-prescription) \_\_\_\_\_

Are you allergic to any medications? No  Yes  If yes, list medication(s)

**Review of Systems:** Do you have any of the following TODAY?

**Gastrointestinal**

- Heartburn/Reflux
- Nausea/vomitory/diarrhea

**Skin**

- Rash

**Neurological/Head**

- Headaches
- Weakness
- Migraines

**Ears/Nose/Throat/Mouth/Neck**

- Hay fever/allergies/congestion
- Sinusitis
- Neck Problems

**Genitourinary**

- Painful/Bloody Urine
- Leaking Urination

**Psychiatric**

- Anxiety/Stress
- Sleep Problems
- Psychiatric Illness

**Cardiovascular**

- Chest Pains/Discomfort
- Palpitations
- Shortness of breath with exertion

**Musculoskeletal**

- Muscle/joint pain/arthritis
- Recent back pain

**Respiratory**

- Cough/wheeze
- Shortness of Breath

**Blood/Lymphatic**

- Blood Disease
- Unexplained lumps

Patient Signature \_\_\_\_\_

Technician Signature \_\_\_\_\_

# Ophthalmology Consultants, Ltd.

## Patient Record of Disclosures

HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

The following form is to be used to signify the alternative means for sharing PHI information:

I wish to be contacted in the following manner (check all that apply)

### To whom may we talk to about your medical and billing information?

- Name of Spouse \_\_\_\_\_
- Name of Parent \_\_\_\_\_
- Name of Child \_\_\_\_\_
- Other \_\_\_\_\_
  
- Home Telephone (      ) \_\_\_\_\_
  - O.K. to leave message with detailed information
  - O.K. to leave message with call-back number only
  
- Work Telephone (      ) \_\_\_\_\_
  - O.K. to leave message with detailed information
  - O.K. to leave message with call-back number only
  
- Written Correspondence
  - O.K. to mail to my home address
  - O.K. to mail to my work/office address
  - O.K. to fax to this number (      ) \_\_\_\_\_

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Date of Birth